



MISSISSIPPI STATE DEPARTMENT OF HEALTH



Make a Child's Smile - Parental Consent Form

The Mississippi State Department of Health provides a preventive dental service for children in Head Start. With your permission, a dental hygienist will evaluate your child for obvious dental problems, such as a tooth cavity, and you will be informed of the results of your child's dental assessment. The dental hygienist will also apply a thin coating of fluoride varnish on your child's teeth to prevent tooth decay. The dental hygienist may return later in the school year to provide a second fluoride application for your child, as feasible. These services are performed on-site at the school in a friendly environment. The hygienist may also assist the Head Start staff with your child's referral to a dentist for examination and needed treatment. For your child to receive these benefits, please check "Yes" and return the signed form to your child's teacher tomorrow.

YES

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I would like my child to have a dental assessment and receive preventive fluoride varnish. Please write your child's name and sign and date the form in the appropriate space below.

NO

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I do not want my child to participate in this preventive dental program. To help us understand your concern, please write the reason why you do not want your child to participate on the other side and return the form to your child's teacher.

I hereby consent, on behalf of my child, _____, to receive any dental services described above that are deemed necessary. I have placed a check mark in the appropriate box indicating my consent for treatment. I understand that the dental services described above will be provided at no additional cost to me or the Head Start and I will receive a written report about the services received. I also understand that this service does not replace a comprehensive examination by a dentist. I understand that, if eligible, the Mississippi State Department of Health will bill Medicaid for the services rendered. I also authorize the Mississippi State Department of Health to release my child's health information to other dentists, physicians, nurses, health care providers and social service agencies who may provide consultation, referral, and treatment services for my child.

Parent/Guardian Name (please print) _____

Contact Phone Number: _____

Parent/Guardian Signature _____ Date _____